

Applied Assessments LLC

An Independent Review Organization

Phone Number:
(512) 333-2366

2771 E Broad St. Suite 217 PMB 110
Mansfield, TX 76063

Fax Number:
(512) 872-5096

Email: appliedassessments@irosolutions.com

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology

Description of the service or services in dispute:

1 SEG (stellate ganglion block)

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who initially presented with a left shoulder injury. The procedure note date strength at the radial arthrogram of the left shoulder dated XX/XX/XX revealed a few tiny subcortical cysts in the superior lateral aspect of the left humeral head. No other remarkable findings were identified. Okay the clinical note dated XX/XX/XX indicates the patient complaining of left shoulder and back pain. There is an indication the patient had been diagnosed with a chronic winged scapula as well as accessory nerve palsy. The current use of tramadol was proving not helpful. The patient had been recommended to utilize Motrin or Aleve at that time. The clinical note dated XX/XX/XX indicates the patient continuing with left shoulder pain. There is indication the patient past medical history is significant for a prior sir shoulder surgery. The patient reported findings consistent with fatigue. There was also indication patient had findings of tinnitus. Paresthesia and weakness were identified in the upper extremities. Patient also reported findings consistent with anxiety as well as an increase in stress along with sleep disturbance and difficulty concentrating. The clinical note dated XX/XX/XX indicates the patient reporting left upper extremity pain with radiating pain into the arm and upper back. There is indication the patient has findings consistent with reflex sympathetic dystrophy in the upper extremities. The patient reported strength deficits at the fat at the thumb with abduction and finger flexors. The patient also was identified as having decreased range of motion. The note indicates the patient having been recommended for a stellate ganglion block.

The utilization reviews dated XX/XX/XX and XX/XX/XX resulted in denials for a stellate ganglion block as insufficient information was submitted confirming the diagnosis of CRPS/RSD confirming the appropriateness of the stellate ganglion block. Okay less go

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The documentation indicates the patient complaining of left upper extremity pain, specific at the shoulder. There is indication the patient has shown signs of CRPS left upper extremity. The use of a stellate ganglion block is indicated for patients who have exhausted all other conservative treatments and the patient has been identified as meeting all necessary Budapest Hardin criteria in order to proceed with the sympathetic block. No information was submitted regarding the patient's completion of any conservative treatments addressing the left upper extremity issues. Furthermore, while there is indication the patient has shown signs of RSD, no other information was submitted confirming the patient's ongoing symptomology associated with the diagnosis. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that

the request for a stellate ganglion block is not recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)